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ABSTRACT

The document summarizes proceedings of an August 1980 conference on early intervention programs for developmentally disabled children attended by representatives of public instruction, federal and state model programs, early childhood staff from university affiliated facilities, instructors from colleges and universities and graduate students. Discussion is reported on two central themes of the conference: child assessment and parent training. Assessment discussion focuses on such topics as instruments used, assessment of severely motorically involved children, role of the environment, parent's role, optimum time, use of developmental ages, differences between evaluation and assessment, and use of assessment scales based on normal development. Nine principles in assessment are summarized. Discussion on parent training addressed current efforts in this area as well as pressing problems (e.g., ways to involve reluctant parents and approaches for dealing with unrealistic parent attitudes) and new directions (including improved training of medical personnel in early childhood development). Appended are descriptions of regional early intervention programs. (CL)

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Central Conference
of University Training Programs
in Developmental Disabilities

EARLY INTERVENTION PROGRAMS FOR DEVELOPMENTALLY DISABLED CHILDREN

Conference Proceedings

Indianapolis, Indiana

August 25 and 26, 1980

Edited by:

Susan K. Shuster

Cynthia L. Groman

Sponsored by:

The Ohio State University Research Foundation in conjunction
with the Region V UAF Consortium Project

and the

Unit for Model Program Development and Dissemination
Developmental Training Center
Indiana University

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TABLE OF CONTENTS

	Page
Preface	i
Introduction and Conference Overview	1
Discussion on Assessment	3
Discussion on Parent Training	12
Summary Statement	16
Program/Project Descriptions	17
Bibliography	23

PREFACE

About the Unit for Model Program Development and Dissemination...

The Unit for Model Program Development and Dissemination of the Indiana University Developmental Training Center serves as a catalyst for the provision of comprehensive services to handicapped children and their families.

The unit considers itself a model for demonstrating the delivery of comprehensive and interdisciplinary services, and a training site for preservice and in-service professionals, paraprofessionals, and parents. Research and inquiry related to parent-child interactions, instructional strategies, and other topics are seen as key activities in the unit. It is committed to maintaining the service functions already in operation through demonstration, training, and research, while building upon this base to extend and expand its field-based consultative effort.

The unit currently consists of three model demonstration programs, a curriculum development project, and a field-based diagnostic and assessment program.

Program PREPARE, formerly a federally-funded model demonstration program for handicapped infants and toddlers and their families, is now state-supported and provides services to families of young handicapped children as well as technical assistance to service providers within Indiana.

The Monroe County Multi-Categorical Model Preschool Program is a federally-supported model demonstration program for handicapped preschool children ages 3-5. A joint effort with the Monroe County Community School Corporation and the Indiana Department of Public Instruction, the preschool has as its goal the successful integration

of handicapped preschoolers into the public school.

The Indiana Home Teaching System project, formerly funded by the Indiana Department of Mental Health and now funded by Region V HEW Developmental Disabilities Office, is designed to provide a comprehensive, coordinated, cost-effective system for young handicapped children and their parents living in rural areas. Designed for agency and/or home utilization, it was field tested in the six states of Region V and is currently being revised.

The Autism Program, formerly a federally-funded model demonstration program for autistic and autistic-like children, is not state-supported and provides a residential program for a select group of children, and training for their families, and their local education agency personnel. The goal of this program is to reintegrate the children into their home communities and to provide technical assistance to other service providers within Indiana.

The Diagnostic and Assessment Program staff provides families, local education agencies, and other community agencies (i.e. Head Start) throughout Indiana with assistance in assessment, program planning, and program implementation for children suspected or already labeled as handicapped.

The unit personnel also work closely with the Division of Special Education in the Department of Public Instruction for purposes of training, dissemination, and technical assistance.

INTRODUCTION AND CONFERENCE OVERVIEW

Introduction

In April, 1980, the Indiana University Developmental Training Center was awarded a contract by the Ohio State University Research Foundation in conjunction with the Region V UAF Consortium Project. The purpose of the contract was to plan, develop, and conduct an Early Childhood Consultation Conference dealing with early intervention of developmental disabilities, as proposed by the Central Conference of University Training Programs in Developmental Disabilities.

The purposes of the conference were as follows:

1. To enhance knowledge about the status of early intervention programs in Region V.
2. To facilitate the identification and coordination of various state and federal programs.
3. To utilize current knowledge of programs and practices within the region in the planning for the future.

Organization of the Conference

The conference was held on August 25 and 26, 1980, in Indianapolis, Indiana. Designed to enhance the sharing of early childhood program efforts, the participants first identified two areas for group discussion, that of parent training, and assessment of children. These discussions were facilitated by staff of the Developmental Training Center. Opportunities were then provided for individual presentations from participants representing programs and projects currently operational within the region.

Conference Participants

The conference participants were representatives from departments of public instruction, federal and state model programs, Early Childhood

staff from University Affiliated Facilities, as well as instructors from institutions of higher education, and graduate students.

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DISCUSSION ON ASSESSMENT

The initial discussion addressed a variety of questions relating to the assessment of the young handicapped child. Each of the conference participants posed related questions. These questions served to frame the discussion that followed.

1) What assessment instruments are being used with the very young population?

The participants were interested in learning from each other what kinds of assessment instruments were being used and which ones were

found to be the most useful, the most appropriate, and the most easily understood.

2) How does one assess a child who is severely, motorically involved?

The concern raised was the inappropriateness of many standardized tests for a child who is not able to produce any sound or move parts of his body in order to respond to questions or to perform requested actions/behaviors.

3) What is the purpose of assessment?

How does one determine the function of an assessment scale? Is it to generate an I.Q. score or a social quotient? Is it to assist the professional staff in making programming decisions or is it a means of measuring change and therefore the need for an instrument that has the capability of being utilized over and over again.

4) The role of the environment. What is the influence of the environment in which the child is being assessed?

Many questions were raised concerning the appropriateness of the natural environment, the child's familiar environment, familiar toys, familiar setting, to serve as a "support system" while trying to determine the level of functioning of a particular child. This would be in contrast to the more frequent or more standard procedure of removing the child from the familiar environment and putting him into an environment in which the sole purpose was to measure the particular area of development, and typically an environment devoid of distractions.

5) Who does the assessment?

The questions focused on the value of the primary caregivers vs. professionals in providing the kinds of information that is desired for assessment. Is the professional trained in the use of the instrument, able to recognize appropriateness of response or inappropriateness

of a particular item, etc., for a specific child? What kinds of information could the primary caregiver provide to facilitate the assessment?

6) What role does the parent play in the assessment process in addition to the potential role of providing information?

Can or should the parents administer most if not all of an assessment? Should the parent be present during the assessment of the child to enhance the comfort of the child? If the child is not able to respond to an unfamiliar assessor, to what extent can we and should we rely on parents reports of the particular behavior that the child may have demonstrated in a different setting? To what extent can we use that information?

7) Is there a need for standardized testing when talking about the assessment of young handicapped children?

With this population and the different kinds of handicapping conditions, the issue becomes one of deciding on whom is the test standardized and what purpose does that serve? Again, the notion of using an assessment device for generating a score seems to be short-sighted and limited when programming and planning for a very young handicapped child. However, the issues of comparability across tests and reliability and validity within the test do suggest some caution in the use of results for comparison purposes, comparison with other children or comparison with other tests.

8) What is the optimum time for an assessment?

The questions here are the frequency of assessments for a child, the length of the individual testing period, and concerns for protecting the youngster so that the child is not placed in an unduly arduous setting for purposes of generating information about his performance. Again the question is raised concerning the validity of the parent

report and/or the parent administering the assessment in a more familiar environment.

9) What is the difference between evaluation and assessment?

This question generated much discussion. Perhaps for the young handicapped child, an evaluation and an assessment may be thought of as similar. Perhaps what we really want is a descriptive pupil progress or pupil change measure. The evaluation question becomes broader when we recognize and attempt to determine the effects of parent participation, enthusiasm of the child, attendance of the child, decrease in medical difficulties, etc.

10) Should developmental ages be used?

The questions here evolved around the usefulness and utility of incorporating developmental ages on assessment scales used with children who are clearly delayed in significant ways. To what extent do the developmental ages guide programming? From the other perspective, perhaps developmental ages serve as a depressant when the information is shared with the family. In other words, if one knows from observation that the child is going to be delayed, to what extent do we need to display the developmental age, per se? In contrast, perhaps the developmental age is useful as a way of looking across developmental areas or in the form of a profile. There was uncertainty in the group about the real function of developmental ages.

11) What happens after assessment?

A grave concern addresses the next step after an assessment or an evaluation is completed. If programs do exist, it becomes a question of what kind of program should be designed for a child based on the assessment information. Who is best to deliver a certain kind of program? What if there is no appropriate program?

12) How can we identify skill clusters in assessment?

How can we cut across the assessment results generated in separate developmental areas to form a better understanding of skills that might cluster together?

13) Should we use assessment scales based on normal development?

Are these scales appropriate or as we learn more and more about the young handicapped child are we now in a position to try to design some assessment scales that are more appropriate to the severely handicapped child? We know, for example, that the severely motorically involved child is never going to proceed through the normal progression to achieve the major milestone of walking. Is it not possible to design an alternative? Most professionals still tend to rely on the more traditional normal developmental scales and at the same time are not satisfied. We hope that efforts to explore this area will increase.

Other discussion topics

The questions raised by the participants led to more indepth discussions on several topics related to an analysis of the youngster's needs and his learning environment. The young handicapped child is one who typically has an observable and in many cases significant disability. There was much concern about the tendency of many professionals to apply normal developmental scales as if they were a standardized instrument to be administered in only one way. Everyone emphasized the need for professionals to be flexible and to adapt where necessary when doing assessments. Again, the concern was focused on the very uniqueness of each young handicapped child and the need for professional staff to recognize that uniqueness and to try to plan for it in any assessment endeavors.

Another issue emerged relative to the readiness question. One of the criticisms of the early intervention movement to which the program participants were very sensitive was the dilemma involving the extent to which a child may be "pushed" too fast by the professional who doesn't wait for the signs that the child is ready. Extensive discussion addressed the recognition of a child's readiness for a new experience. This is a difficult area for professionals who work with children who don't necessarily have the capabilities to express the interest, show the curiousity, or approach the new toy or new task (because of a motor or sensory impairment). There was consensus that the ideal assessment/programming device or tool would be one that would have built into it a set of decision points. Such a "road-map" would provide for the child who doesn't follow the sequence or may not be ready to do a particular task. It would suggest the next step, so that the assessor would have a series of alternatives for a child for whom a particular step was unattainable at that moment. An assessment scale with a decision making component may facilitate the identification of specific areas of need as well as the development of appropriate programs.

Criticism was generated against the utilization of the Bayley Scales, which, excellent for normal children, are very inappropriate for the multiply handicapped child who just does not have the behaviors. Criticisms were also shared relative to the Uzgiris and Hunt's Scales becuase they are based on the concept of behavioral growth as linear and hierarchical. In reality, the linear concept is only a part of development. The need is for a more finely calibrated assessment device, one that is fine tuned to show very slow changes. It was suggested that the observation and assessment of the child's progress may be more

appropriate if we would use a "small ruler rather than the usual yardstick." Several participants pointed out that a hierarchical assessment device, that presents the sequence of development in a particular area or domain, can provide information to guide our programming and our teaching.

In summary, the discussions centered on the kinds of assessment strategies and instruments to be used with the young handicapped child, a delineation of purposes, and the need for more finely tuned appraisals of children's development. If the assessment devices are not "fine tuned," their appropriateness of adequacy as guides for programming for the young handicapped child is questionable.

Moving from the issue of the assessment devices to the question of who should be doing the assessment, there was much support for the utilization of the primary caregiver to assist in the assessment process. It was strongly felt that the parent, though certainly much more involved and valued in programming than has been the case heretofore, is still underutilized as a source of information about children's progress and capabilities. Several programs for the young handicapped child are exploring the utilization of parents for their child's assessment. These efforts are being mounted by providing parents with guidelines or indications of what to look for. Not only have these efforts resulted in some very useful information but serving in a "consultant" role has clearly enhanced the parents' interest and willingness to become involved with their children's program. We can help parents become more effective assessors by asking them to observe the functional aspects of their child's behavior. Parents can become a valuable source of information if we (1) ask parents to observe <u>specific</u> behaviors, (2) rely on parents for many "answers,"

and (3) assist the parent in developing a graph or chart of the child's developmental progress.

Suggesting that the assessment of the child become a shared responsibility between the parent and the professional poses some very sensitive questions and will require very careful analysis, discussion, and thinking. A study that compared the results of parents' assessments and professionals' assessments found them to be similar (Pediatrics, January, 1979). This is not to suggest that the professional completely delegates his/her responsibility to the parent, but that we acknowledge the relevance and reliability of the parents' reports, particularly when they observe and can share what the child is really trying to do (intentions). From that information, perhaps, we can then decide at what point to utilize the developmental scales and how to utilize our time in assessment. Clearly, all assessment information from all sources must be incorporated into the program design.

Assessment of child-family interaction

The discussion then turned to the assessment of child/family interaction. The desired outcome of these efforts to assess child-family interaction will be information to generate profiles of babies' behaviors. These can then form a framework for generating expectations about what the child will be able to do in the future. In other words, the child's behavior in a natural setting in interactions with the caregiver provides the base for describing his or her accomplishments and suggests some next steps. By looking at continuous behavior as reflected in observed parent/child interactions, we can look for the intent. What is the child trying to do? What does it seem the child is trying to do? The development scales are not designed to measure

intent. They set up the task and then ask the child to perform. The conference participants were very frustrated with that approach and are eager to try out some more "free flowing analysis" at the point of the baby's demonstrated behavior.

The assessment of interactions would also facilitate the analysis of behavior over time. If the analysis of the child is done on a day-to-day basis utilizing the child's behavior in his environment, more information is generated and more useful "next" steps can emerge from that work. The alternative is the bringing of the child into an assessment once or twice a month and potentially having very limited carry over value.

Mother-child relationship

The discussion then focused on some issues in mother/child interaction and the relationship of that to child development in terms of children's behavior. Studies were shared and discussed which looked at differences between abusing mothers, normal mothers, and mothers who neglected their children and the effects on the child's behavior, and the subsequent effect that the child's behavior had on the mother. These complicated interactions are generating much interest, particularly in terms of programming the interaction to enhance the development of the child.

Suggested principles in the assessment of the young handicapped

In summary, there was enthusiasm and commitment to a variety of operational principles which were deemed appropriate, useful, and relevant to the assessment of the young handicapped child:

1) The developmental scales need to be integrated in terms of their items so as to present a wholistic picture of the child

thus enhancing the parents' interests and motivation in working with their child.

2) Parents need support, encouragement, and help in selecting the "next step" activity.

3) Since we don't know exactly what the developmental sequences are for handicapped children though the assumption is that they follow the normal developmental sequences, it is our responsibility to expand their environments in as many ways as possible and wait for their successes to guide the next step.

4) In facilitating the involvement of parents through the use of play activity books, toy lending libraries, etc. we need to provide clues or guiding information to help parents select toys, games, and materials that cut across developmental areas.

5) We want to foster the play environment as the most appropriate setting in which programming and parent involvement can interface and work together to not only foster development but to enhance the enjoyment of all participants.

6) As professionals we have the responsibility to avoid judgmental behaviors.

7) Assessment should lead to teaching.

8) Stay on the positive side - what the child "can do"; assessment should optimize the child's ability to function.

9) Recognize the child-parent transaction, and the influence of the environment; avoid judgment or evaluation of child-parent transactions and try to suggest alternative transactions for new or positive experiences for the child.

DISCUSSION ON PARENT TRAINING

The second discussion focused on parent training. The conference participants shared their interests and efforts which included:

1) The value of emotional support.

2) The need for valuing parents as partners.

3) The need to breakdown the professional jargon.

4) Recognizing and reinforcing parents as teachers of infants and as teachers of other persons in particular professionals.

5) Parent training needs to be viewed on an individualized basis.

6) The recognition that parents' roles change, that they can accept responsibility and can make decisions.

7) The need to include both parents, and other family members not just the mother or the primary caregiver.

8) The need for parents to be successful themselves before we show them how we do it.

9) The use of parents as assessors.

10) Understanding the outcomes of model programs in terms of benefits to the parents. The provision of a supportive environment for the families to direct their efforts may be the real reason for these programs.

11) The service delivery and the training of parents must go together, in a whole family approach.

12) There are increasing requests coming to many Departments of Public Instruction and State Education agencies for inservice training on parenting skills; the interest is there and it is time to meet that interest.

13) Parents want something that is useful to them that they can do with their child.

14) With many professionals parents are still not seen as valuable assets. This has to be changed.

15) Parents need to be involved in providing service to other professionals.

16) The notion of parent support groups serving as resources to other parents, for problem solving and other pressing needs is essential and must be set up wherever parent groups are available.

17) The issue of modelling for parents in terms of their children was seen as a very controversial one. Modelling to a parent may suggest an incompetence level on the part of the parent; perhaps the alternative is to talk to the parent about a particular thing at the same time trying to show the parent what you are doing with the child. It's not just a "Watch me. Watch what I do," but "I'm doing this because I think it would be better" or "I'm doing it this way because the child seems to prefer it this way."

18) The individuals who are involved in phone conversations, and communications, the intake workers and social workers, must have training in being able to deal with the kind of responses and needs that parents express.

19) A warm and mutually supportive interpersonal relationship between the professional staff and the family is essential. There must be the feeling of cooperation and joint efforts, joint programs, and joint partnership. For example, the use of first names is essential. This feeling of "family" must be present if these programs are going to work and if the parents are going to get the kind of support they need.

Pressing Problems

The participants then focused on the kinds of problems they felt were the most pressing in terms of parent involvement, parent training, parent programming:

1) How do you get to those parents who really don't want to participate? How do you reach them, how do you get them involved, how do you get them to be committed to their children?

2) What do you do with the families who just don't have the resources, time, energy, emotional stability, and/or finances to participate actively? What can you do with them?

3) What do you do for the parents who just won't come? They're interested and they say that they are going to come and they don't show up.

4) How do we keep reminding ourselves that we cannot step into the parental shoes, we can't take over as much as we would like to because we won't be around after the child has outgrown our program?

5) How do we help the parents lean on and ask for help from their own families? How do we build the interfamily networks and the intergenerational networking?

6) How do we help parents respond to the demands placed on them by the other children, by the siblings of the nonhandicapped?

7) How do we confront each other and parents around the issue of whether we say there is a chance for improvement or there is not much chance for change? And what are the implications of our predictions and our prognostications in terms of parent involvement?

8) How do we deal with the perceptions that parents have which we, as professionals, feel are unrealistic in terms of the potential of the child? What do we do with their perceptions and our perceptions and is there a need for our perceptions to be consistent?

9) And how do we handle our own dismay when we want to push parents harder and harder to do things with their children and they won't be pushed? How do we deal with our own frustrations and our disappointments with those families that cannot do everything that we expect them to do?

New Directions

We then tried to suggest some new directions and ideas that may alleviate some of the problems addressed above:

1) Observations or analysis of parents interactions may be more fruitful than parent training.

2) Learning to play with the child should be the focus for the parent in the infant programs rather than emphasizing the teacher role.

3) We need to know what parents want. They may or may not want the same things as normal parents.

4) The training of medical personnel in the area of early childhood development and handicapping conditions will facilitate the successful operations of interdisciplinary programming and support groups for families of young handicapped children. With increased interest and knowledge on the part of the medical community, the long-term goal will be the preventative approach which will in fact be far more desirable than the remediation approach.

5) As more and more professionals are trained in assessment and programming at the very young level we will see a much more coordinated effort for the diagnostic assessment. Related to this is the need for more interdisciplinary and transdisciplinary sharing and training, so that we can share with each other our expertise and our concerns.

6) As more and more parents express themselves in literature, in journals, and at professional meetings we will become even more cognizant of the power and the capabilities of parents and perhaps will recognize what still is an untapped resource, the primary caregiver. We will become more aware of their needs for support, their need to maintain self-esteem, and their desperate needs for information and array of services.

7) As the research generates more knowledge about the interactional patterns within families of handicapped we will become more cognizant of our expectations in terms of the ability of the family to function. If a family portrays themselves to us as dysfunctional or inadequate by our standards, what does that do to our expectations and our ability to continue to program and work with particular

families? And as the research sheds more and more light on family interaction patterns and the relationship to development perhaps we will be able to provide a finer tuned program geared to the parents needs not based on our expectations.

The third part of the conference provided an opportunity for participants to share their particular programs and these descriptions appear in the appendix.

CONFERENCE SUMMARY

The participants viewed the conference as an opportunity to share information about their respective programs and projects, types of services provided, and the delivery of those services. The opportunity to discuss issues and concerns related to early childhood illuminated similarities as well as differences among the programs and projects. Use of available assessment techniques and the involvement of parents in a program seemed to be vital concerns of most of the participants. A concluding theme of the conference emphasized the necessity of gathering information from represented programs/projects - particularly services provided - and the need for an effective means of disseminating the gathered materials. It was agreed that conferences which provided opportunities for sharing programs and concerns should be organized frequently and made available to more people.

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MULTI-CATEGORICAL PRESCHOOL

Characteristics of Target Population

The Multi-Categorical Preschool is a model demonstration program serving twenty children between the ages of 3 and 6 years with various handicapping conditions that range from severely/profoundly handicapped to children who are at risk. The two classrooms are housed within University Elementary School and each staffed with one Demonstration Teacher and one Instructional Associate.

Program for Children

The Preschool is a model for serving young children with special needs within the public school system. A major emphasis is that of providing the least restrictive environment and integration into the mainstream whenever possible and appropriate.

A broad range of comprehensive services are offered to the students and their families. They include: a) Case Conferencing and IEP development as outlined in the Monroe County Schools, b) Parent Education, c) Speech/Language, Physical and Occupational Therapy, d) Social Services, e) Adapted Physical Education, f) Transportation and g) Interdisciplinary staffings.

Assessment Techniques

Each child is Case Conferenced into the Preschool according to the regulations of Indiana's Mandatory Special Education Services Act and the Monroe County Community Schools. After entry into the classroom each child is assessed by the Demonstration Teacher with various developmental instruments. Those most frequently used are the 1) Indiana Home Teaching System and 2) Portage Developmental Profile. Specialized staff assess the children in very specific areas of development -- such as sppech/language and motor -- using an array of methods and instruments that yield information for programming.

Curriculum

The curriculum incorporates basic Early Childhood Education practices while providing those therapeutic services necessary for remediation and/or prevention. The developmental model is the framework for the Preschool curriculum and instruction, with emphasis on acquisition of those skills necessary for entry into public schools -- both regular and special education.

Program for Parents

Parents are viewed as planners and advocates for their children. The Parent Education component is individualized to meet the needs of each parent as determined by the Parent Needs Assessment. Large and small group meetings, home visits by the Demonstration Teachers and involvement in the IEP process are examples of activities in which parents participate.

Funding

The Multi-Categorical Preschool is a cooperative venture of Indiana University Developmental Training Center, Monroe County Community School Corporation and the Indiana Department of Public Instruction and is funded by the Bureau of Education for the Handicapped.

Project Coordinator: Gen Shelton

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INDIANA HOME TEACHING SYSTEM

The Indiana Home Teaching System (IHTS) is a comprehensive and interrelated system of developmental assessment and instruction.

It is designed to:

1. Provide professional personnel with a comprehensive model for the delivery of services to handicapped preschool children and their families within the home environment.
2. Establish a developmental profile of each child.
3. Provide appropriate home instruction through a home teaching curriculum and related parent teaching materials.

Originally funded by the Indiana Department of Mental Health (1975-77), the project is now funded by the Office of Developmental Disabilities, Region V, Department of Health, Education and Welfare.

The IHTS consists of four sets of materials designed to meet the above goals.

1. Administrative Sourcebook for Preschool Services

This guide provides the Agency Director or Program Director with information needed to either institute preschool services or expand existing services. It provides a detailed description of a delivery of service model for home (and agency) instruction. Further, it includes information on community needs assessment, community awareness campaigns, staff needs and development, parent education programs, and monetary resources for program support.

2. Indiana Preschool Developmental Assessment Scale

The Indiana Preschool Developmental Assessment Scale (IPDAS) is a 300 item instrument designed to assess the developmental progress of handicapped children from birth to six years. It obtains developmental measures in the areas of Gross and Fine Motor, Receptive and Expressive Language, Social, Preacademic and Personal Autonomy. A section of Reflex Behavior has been included but is considered an optional area for assessment.

The assessment instrument has been divided into two notebooks labeled "Assessment I" and "Assessment II." "Assessment I" contains the items for Reflex, Gross Motor, Fine Motor and Language. "Assessment II" contains Social, Pre-Academic, and Personal Autonomu. It is important to note that the corresponding home teaching curriculum notebooks--"Basic Skills and Application"--follow the identical sequence.

3. Indiana Home Teaching Curriculum

The Indiana Home Teaching Curriculum is designed for parents to use with their handicapped child in the home. The Curriculum teaching objectives correspond directly to the developmental skills assessed in the IPDAS.

To assist the parent, each objective specifies the teaching sequence, suggested materials and alternate methods of teaching to each objective.

4. Parent Resource Teaching Guide

The Parent Resource Teaching Guide is designed to provide parents who are using the Home Teaching Curriculum with basic information on teaching. Further, it addresses itself to the daily living problems they may encounter with their handicapped child. Attention is given to the role of the parent as a planner for their child and as an advocate for their handicapped child--and all handicapped children.

INDIANA UNIVERSITY | DEVELOPMENTAL TRAINING CENTER
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Program PREPARE

Characteristics of Target Population: Program PREPARE is an early intervention program for infants/toddlers and their families. PREPARE serves children from birth to three years of age who are developmentally delayed or "at risk" with a broad range of limitations and abilities.

Program for Children: Based on each child's individual needs, a child and his/her family may participate in one of two program options: home based or classroom. It is possible for families to participate in a combination of these options as well. The classroom program integrates handicapped and non-handicapped children from 18 months to 3 years of age. These children participate four days a week in a classroom setting which combines small group activities with individual instruction. The home based program is for infants under 18 months of age or for those children who for some reason cannot attend the classroom. Although primary emphasis is on parent training in the home, children are evaluated on a regular basis by the specialized staff during clinic sessions on Fridays. An interdisciplinary staff provides the following services: physical therapy, speech/language/hearing therapy, specialized health services, special education and parent education.

Assessment: Classroom teachers, the speech/language/hearing specialist and the physical therapist use a variety of assessment guidelines and instruments including the Indiana Preschool Developmental Scale. The first Thursday afternoon and Friday morning of each month are set aside for initial evaluations of referred children. During the first session, a natural play setting is constructed for several children. The interdisciplinary team makes observations of the child's interactions with materials, other children and their parents. Team members also have an opportunity to talk with parents. During the second session on Friday morning, team members structure more formal interactions with the children in order to complete their assessments. On-going evaluation and assessment is continued after the child is enrolled in the program with formal progress reports written every three months.

Curriculum: In support of P.L. 94-142 both home and classroom programs provide Individualized Education Programs for each child in the following areas: gross motor skills, fine motor skills, language skills, social and play skills, pre-academic skills and self-help skills.

Program for Parents: Parents actively participate in the program in an effort to increase their skills as effective teachers, planners and advocates for their child. Through experiences in the classroom and with the staff, parents have an opportunity to become a learning resource for their child. Parents also have opportunities to meet with other parents who have children with developmental delays, to plan for their child's future needs, and to become advocates for the legal and educational rights of their child. Through parent needs assessments, Individual Parent Plans are developed to plan and implement each family's involvement on an individual basis.

Michael Reese Hospital and Medical Center
David T. Siegel Institute for Communicative Disorders
Dr. Robert Henner Hearing & Speech Center
29th Street and Ellis Avenue
Chicago, Illinois 60616
Tel. (312) 791-

HI-MAPS PROJECT

The HI-MAPS Project at Siegel Institute is a three year federally funded model demonstration program providing medical, academic and psychological services to hearing-handicapped infants and their families. The major purpose of HI-MAPS is to help young children with severe and profound hearing losses achieve their maximum potential during the critical learning period from birth to 3 years of age. The program focuses on three areas:

1. The early medical identification of infants judged at risk for hearing impairment.

2. The provision of educational services for children and parents to stimulate language, cognitive and social development. Staff members model for parents a Total Communication approach to language by using sign language in conjunction with aural/oral training.

3. The provision of psychological services for the parents to strengthen the parent-infant bond and provide parents with emotional support.

Educational sessions for each parent-infant dyad are held once a week. Equally important are the weekly parent counseling group and sign language/communication skills class, which parents attend while their child participates in a play group for deaf children. The project views parents as the primary people interacting with and caring for their deaf infants; thus the program's emphasis is on facilitating parent-child communication and interaction.

The HI-MAPS staff includes a child development specialist, parent counselor, developmental psychologist, preschool teacher of the deaf, communication skills specialist, teacher aide, and clinical audiologist. Supportive staff members include a speech/language clinician, otologist, electrophysiologist, pediatric neurologist, ophthalmologist, and occupational therapist.

The HI-MAPS Project is funded through the Handicapped Children's Early Education Program, Office of Special Education, U.S. Department of Education. Under the provisions of the grant, parent-infant services are offered at no cost to participating families. Inquiries and referrals should be directed to:

Valerie Feldman, M.Ed.
HI-MAPS Project
David T. Siegel Institute
Michael Reese Hospital and Medical Center
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Phone: (312) 791-2900 TTY: (312) 791-3449

Affiliated with the Jewish Federation of Metropolitan Chicago and the Division of Biological Sciences and Pritzker School of Medicine of the University of Chicago

CHILD EVALUATION CENTER

334 EAST BROADWAY
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TEL. (502) 588-5331

UNIVERSITY OF LOUISVILLE
SCHOOL OF MEDICINE

DEPARTMENT OF PEDIATRICS

BERNARD WEISSKOPF, M.D., DIRECTOR

The Child Evaluation Center is an interdisciplinary diagnostic unit within the Department of Pediatrics, School of Medicine, at the University of Louisville. The Center's function is to provide comprehensive interdisciplinary evaluations of multihandicapped children and their families, as well as provide specialized treatment programs based on needs in the community. In addition, the Center provides training programs for professionals in various disciplines, provides teaching programs within the academic community, supports and generates research projects, and serves as a catalyst within the community to establish and stimulate programs for multihandicapped children and their families. The Child Evaluation Center is composed of eight units: A Diagnostic and Evaluation Clinic; a Learning Disorders Clinic; a Clinical Genetics and Dysmorphology Unit; a Genetic Laboratory Service; a Prenatal Genetic Diagnostic Service; an Infant Therapy Program; Demonstrative Treatment Programs; and a Community Clinic Outreach Program. The staff consists of professionals in the following areas: pediatrics, psychology, social work, nursing, behavior, education, speech-language pathology, physical therapy, occupational therapy, audiology, genetics, nutrition, and religion. In addition, numerous medical consultants are utilized in areas such as pediatric ophthalmology, neurology, and dentistry.

PRE-START: A FAMILY-FOCUSED MODEL OF SERVICES FOR HIGH-RISK INFANTS

FISCAL AGENCY: Department of Pediatrics, Loyola University Stritch School of Medicine

ADDRESS: 2160 S. First Avenue, Maywood, IL 60153, phone: 312/531-3499

PROJECT STAFF:

Jennie E. Swanson, Director
Louise Bagnuolo, Nurse Consultant
Diane Borucki, External Evaluator
Ron Schmerber, Parent Coordinator
Margaret Brennan, Family Counselor
Craig Anderson, M. D., Medical Consultant
Silvio Aladjem, M. D., Medical Consultant

PHILOSOPHY OF THE PROGRAM:

The Pre-Start Model is designed to emphasize and enhance the competencies of parents and their children. Parents who feel competent and who interact with their children through competency-based perspectives and who operate in a partnership with professionals, will likely enhance their child's growth and development even under adverse circumstances. It is through early and on-going support to families that project personnel strive to effect a positive outcome.

CHARACTERISTICS OF TARGET POPULATION:

The project serves the families of high-risk infants from a neonatal intensive care unit who were born at Loyola University McGaw Hospital or transferred to the hospital from 12 community hospitals. Services are available to children until age 3.

PROGRAM FOR CHILDREN:

The Pre-Start project is neuro-developmental and interdisciplinary in approach and is based on a family-child competency model. Each child's competencies are described as a basis for more successful parent-infant transactions.

MEASURES OF CHILD PROGRESS:

Measures include the Apgar (at birth); Assessment of Term Characteristics (at birth and within 10 days); DDST and the Swanson Infant Follow-up (at 1, 3, 7, 12, 18, 24, and 30 months); Parent Questionnaire (7 and 30 months); Schmerber Parent Attitude Survey (at term, one and three months, and one year), and a pediatric neurology exam (once a year, if indicated). The Revised Gesell (Knobloch et al) is administered at 12 and 24 months. All of the data (prenatal through 3 years) is recorded on custom-designed Op-Scan Computer forms and analyzed as per the PRE-Start Data Management System (Swanson, 1980).

PROGRAM FOR PARENTS:

A team from medicine, education, theology, and nursing serves as a resource to parents, the primary facilitators for infants. Program options include: parent-to-parent support and contact, individual and family counselling, parent groups, information seminars, charting by parents using Partners in Child Development, and crisis intervention. A special focus is on the emotional availability of team members to parents' feelings, needs, and concerns.

INFANT STIMULATION/MOTHER TRAINING PROGRAM
Cincinnati General Hospital/U.C. Medical Center

The program consists of a series of 20 weekly classes that are offered to all adolescent mothers, 16 years and younger, who deliver at Cincinnati General Hospital. The mothers are recruited in the hospital after delivery and classes begin for the mother-infant pairs when babies are approximately 4-6 weeks of age. The classes are educational in nature, providing basic developmental information about infants and appropriate stimulation activities plus information on infant health and nutrition. The structure of the class also provides the mothers with a support group which encourages the mother's attachment to her infant and also her own personal development.

INFANT STIMULATION PROGRAM IN THE INTENSIVE CARE NURSERY

Infant Stimulation is now included in the Intensive Care nurseries, and newborn nurseries as routine care. The purpose of this program is to provide an emotional climate in the nursery which supports the growth and development of the parent-infant relationship. Parents are alerted to the amazing repertoire of newborn behaviors, are shown developmentally appropriate infant stimulation techniques and are helped to resolve their concerns and anxieties about parenting through parent support groups.

UNITED SERVICES FOR EFFECTIVE PARENTING

The Central Referral office for the local U.S.E.P. organization is also located in our Pediatric Department. The U.S.E.P. organization exists both locally and on the state level and is a coalition of health care, educational and social service agencies whose goal is to maximize the potential of both parents and children age birth to three years.

The Central Referral System coordinates, catalogues and follows up on children and family referrals made to all U.S.E.P. agencies.

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